Report

of the

Advisory Panel on Ambulatory Payment (APC) Classification Groups

February 23–24, 2005

Centers for Medicare & Medicaid Services

7500 Security Blvd., Multipurpose Room
Baltimore, MD 21244-1850

APC PANEL MEMBERS PRESENT AT THIS MEETING:

Marilyn K. Bedell, M.S., R.N., O.C.N.
Albert B. Einstein, Jr., M.D.
E. L. Hambrick, M.D., Chair
Lee H. Hilborne, M.D., M.P.H.
Stephen T. House, M.D.
Kathleen Kinslow, C.R.N.A., Ed.D.
Mike Metro, R.N., B.S.
Sandra Metzler, M.B.A.
Gerald V. Nacarelli, M.D.
Frank G. Opelka, M.D., F.A.C.S.
Louis Potters, M.D., F.A.C.R.
Lou Ann Schaffenberger, M.B.A., R.H.I.A., C.C.S.
Judie S. Snipes, M.B.A., R.N., C.N.A., C.P.C, F.A.C.H.E., C.P.H.Q., C.C.P.
Lynn R. Tomascik, R.N., M.S.N., C.N.A.A.
Timothy Gene Tyler, Pharm.D.
William A. Van Decker, M.D.

CMS STAFF PRESENT:

Shirl Ackerman-Ross (Designated Federal Official [DFO]); Sabrina Ahmed; Carol Bazell, M.D.; Dana Burley; E. L. Hambrick, M.D., J.D.; Anita Heygster; Debbie Hunter; Elizabeth Richter; Joan Sanow; Kenneth Simon, M.D.; Tamar Spolter; and Cindy Yen

WELCOME AND CALL TO ORDER

E. L. Hambrick, M.D., Chair, APC Panel, welcomed the members, CMS staff, and the public. (The proceedings of the meeting follow. The agenda appears in Appendix A; a listing of only the recommendations appears in Appendix B.) Dr. Hambrick reviewed the Panel's charter and explained the "two-times rule" (for example, in a given ambulatory payment classification (APC), the highest median-cost item should be no more than two times the lowest median-cost item). Dr. Hambrick noted the recommendations from this meeting should relate primarily to preparation of the Notice of Proposed Rulemaking for calendar year 2006.

Elizabeth Richter, Director of the Hospital and Ambulatory Policy Group, welcomed the Panel members. She offered special thanks to members rotating off the Panel after this meeting: Dr. Lee H. Hilborne, Dr. Stephen T. House, Dr. Kathleen Kinslow, Mike Metro, Dr. Gerald V. Nacarelli, and Dr. William A. Van Decker.

OLD BUSINESS

No old business was presented.

NEW BUSINESS

Overview of CMS-1427-FC, Final Rule for the Hospital Outpatient Prospective Payment System (HOPPS) and Calendar Year 2005 Payment Rates

CMS Staffer Dana Burley identified some of the changes for 2005. She noted that of 42 APCs that depend on the use of very expensive devices, reimbursement rates for 21 of those were adjusted to moderate the reduction in payment. Also, 25 procedures were moved from new technology APCs to clinicalAPCs because CMS had gathered sufficient claims data. Ms. Burley pointed out that an initial physical examination is a new covered benefit paid by Medicare under the OPPS. The OPPS now pays for diagnostic mammography according to the Physician Fee Schedule.

Overview of Data Issues

CMS Staffer Anita Heygster described how CMS uses pattern analysis of specific APCs when the number of single claims available for determining median costs for those APCs is very low. CMS Staffer Cindy Yen presented the Agency's suggestions (based on 2004 data) for procedures that could be removed from the HOPPS inpatient-only list. Panel members agreed that the procedures suggested are already performed in an outpatient setting in most cases, and they suggested that Current Procedural Terminology (CPT) code 37183, removal of shunts, also be removed from the inpatient-only list.

The Panel recommends removing the following CPT codes from the inpatient-only list:

33420	59100	21408	21150
55600	20822	21495	20663
31293	64763	61334	20972
31294	54560	21175	59856
00634	01190	64766	27475
20662	37195	20973	37183
65273	36510	21195	

CMS Staffer Debbie Hunter asked the Panel whether the CPT codes for planning SRS should be combined into a single G code to simplify data collection. Nelly Leon-Chisen of the American Hospital Association (AHA) said hospitals prefer CPT codes to G codes because all other payors require CPT codes. Rebecca Emerick of the International Radiosurgery Association asked that the Panel wait for input from her organization and others, who were scheduled to meet in March 2005. Ms. Hunter also asked whether G codes for delivery of SRS should be maintained and whether these codes should remain in new technology APCs.

The Panel recommends that CMS create a single G code to encompass planning for SRS, that the code be assigned to a new technology APC, and that the issue of planning codes for SRS be brought before the Panel for review in 2006.

The Panel recommends no changes to the current G codes for delivery of SRS. However, the Panel recommends that CMS staff review the current data and provide the Panel with possible scenarios for moving SRS delivery codes from the new technology APC into individual existing or new APCs.

CMS Staffer Tamar Spolter said the Agency is soliciting comments on improvements to the current OPPS revenue code to hospital cost center crosswalk which is used to develop the cost-to-charge ratios which are applied in the conversion of hospital charges to costs. Ms. Heygster explained the three modifiers used to identify when a procedure is not completed and the corresponding payment reduction guidelines. Marion Kruse of OhioHealth said, and many Panel members agreed, that the resources and staff time involved in a failed or interrupted procedure sometimes exceed that of successful, completed procedures.

> *The Panel recommends* to CMS that claims submitted with modifier 52, 73, or 74 be paid at 100 percent of the reimbursement rate (and not reduced).

Data Subcommittee's Report

Dr. Timothy Gene Tyler presented recommendations of the Data Subcommittee. The Panel accepted the report of the Subcommittee and made the following recommendations:

> *The Panel recommends* that CPT code 33241, in APC 107, be added to the bypass list.
>
> *The Panel recommends* that CPT codes 93640 and 93641, in APC 108, be packaged.
>
> *The Panel recommends* that CMS analyze APCs 81 and 229 for patterns related to multiple claims.
>
> *The Panel recommends* that the Data Subcommittee continue to meet and evaluate issues.

Observation Issues

Joan Sanow, Acting Director of the Division of Outpatient Care, explained the changes made to reimbursement guidelines for observation. The Agency seeks input from the Panel on how to identify other conditions that meet the criteria for the observation list (which currently includes only congestive heart failure, chest pain, and asthma).

Representing the Provider Roundtable, Jennifer Artigue, Ms. Kruse, and Valerie Rinkle suggested other changes that would eliminate G codes for observation services and simplify observation billing procedures for hospitals (Presentation 1). Ms. Lee of the AHA supported suggestions to simplify billing. The Panel asked that the Provider Roundtable submit more detailed suggestions on observation coding and that CMS review observation from a hospital coding perspective to seek simplification.

Observation Subcommittee's Report

Dr. Hilborne said the Observation Subcommittee reviewed condition code 44, used to identify a change from inpatient to outpatient status, and found that fiscal intermediaries have implemented policies regarding this code inconsistently. More education and guidance on the use of code 44 is needed from CMS. For determining the medical necessity of observation, the Panel suggested CMS consider providing guidance on standardizing the criteria, for example, by using InterQual® or Milliman criteria.

The Panel accepted the report of the Observation Subcommittee and made the following recommendations:

> *The Panel recommends* that CMS consider strategies that would allow hospitals to change to the appropriate inpatient or outpatient status after patient discharge but before the patient or payor is billed.
>
> *The Panel recommends* that CMS review data on 1-day stays among inpatient diagnosis-related groups to look for patterns of diagnoses that might be considered appropriately included on the observation list.
>
> *The Panel recommends* that CMS gather data from Quality Improvement Organizations regarding 1-day stay audits among inpatient diagnosis-related groups to look for patterns of diagnoses that might be considered appropriately included on the observation list.
>
> *The Panel recommends* that the Observation Subcommittee continue to meet and evaluate issues.

Panel members were pleased that CMS has been communicating with skilled nursing facilities about the three-day requirement for admission to a skilled nursing facility and urged the Agency to continue such communication. However, Panel members continue to question the utility of the three-day requirement. The Panel asked CMS to allow the hours a patient spends in observation to count toward the three-day requirement.

Packaging Issues

Ms. Spolter said the Agency reviewed all the codes with status indicator N as requested by the Panel. Representing the Provider Roundtable, Ms. Artigue, Ms. Kruse, and Ms. Rinkle supported the proposal that a modifier be used to identify when a packaged procedure is the only item on a claim (Presentation 2) so that it then can receive separate payment. They suggested several currently packaged CPT codes for Packaging Subcommittee review.

Packaging Subcommittee's Report

Dr. Albert Einstein said the Packaging Subcommittee looked at most of the CPT codes identified by the Provider Roundtable. Denise Merino of the Society for Nuclear Medicine requested that CPT code 38792, sentinel node imaging, be reviewed by the Packaging Subcommittee. The Panel accepted the report of the Packaging Subcommittee and made the following recommendations:

> *The Panel recommends* that packaged codes be reviewed by the Panel individually.
>
> *The Panel recommends* that the Packaging Subcommittee continue to meet throughout the year to discuss problematic packaged codes.

The Panel recommends that CMS assign a modifier to CPT codes 36540, collect blood, venous device; 36600, withdrawal of arterial blood; and 51701, insertion of bladder catheter, for use when there are no other separately payable codes on the claim. The modifier would flag the OCE to assign payment to the claim.

The Panel recommends that CMS maintain the current packaged status indicator for CPT code 76937, ultrasound guidance for vascular access.

The Panel recommends that CMS change the status indicators for CPT immunization administration codes 90471 and 90472 to allow separate payment and ensure consistency with other injection codes.

The Panel recommends that CMS gather more data on CPT code 94762, overnight pulse oximetry, to determine how often this code is billed without any other separately payable codes and whether it is performed more frequently alone in rural settings than other settings.

The Panel recommends no changes to the packaged status of CPT codes 77790, radiation source handling, and 94760 and 94761, both for measuring blood oxygen levels.

The Panel recommends that CMS provide education and consistent guidelines to providers and fiscal intermediaries on correct billing procedures for packaged codes in general and in particular for CPT codes 36540, 36600, and 51701 and the recommended modifier, if approved.

The Panel recommends that the Packaging Subcommittee review CPT codes 42550, injection for salivary x-ray, and 38792, sentinel node imaging.

The Panel recommends that CPT code 97602, nonselective wound care, be referred to the Physician Payment Group for evaluation of its bundled status as it relates to services provided under the Outpatient Prospective Payment System and that the Physician Payment Group report its conclusions back to the Panel.

Device-Related APC Issues

Ms. Heygster explained that 2006 reimbursement rates for device-dependent APCs are based on data from 2004, when hospital use of C codes was voluntary. New device edits for specific device-dependent procedures have been posted on the web that must be implemented by hospitals as of April 2005. Additional edits are scheduled for implementation in July and October of 2005, and these are also posted on the web. Many changes to all groupings of edits have been made in response to comments. These edits will prevent payment for the device-dependent service unless a device C code key to the service also appears on the claim. Ms. Heygster presented a table illustrating how the median rates for device-dependent APCs were set for 2005 and how they compare with 2006 median rates.

The Panel recommends that CMS publish the second and third edits for device coding (scheduled for July and October 2005) for implementation together in July, 2005.

The Panel recommends that CMS proceed with caution in using existing data on devices submitted with C codes to set reimbursement rates and that CMS consider using external data in setting such rates, especially for those devices with particularly high costs. The Panel recommends that CMS review and report to the Panel on those situations in which the 2006 median is less than 90 percent or greater than 110 percent of the 2005 adjusted median. When the 2006 median is between 90 and 110 percent of the 2005 adjusted median, the Panel recommends that CMS set reimbursement rates at the higher of the two figures. The Panel recommends that CMS bring data on this issue back to the Panel for consideration when CMS has gathered at least one year of applicable data.

Jane Hyatt Thorpe of AdvaMed asked the Panel to recommend that CMS consider external data in setting rates for device-dependent APCs (Presentation 3). She also asked that the application process for a new technology APC or new device pass-through category be more transparent and predictable, and that CMS model the tracking process after that used by the Inpatient Prospective Payment System.

The Panel reviewed comments submitted by C. R. Bard requesting that C9703, Bard endoscopic suturing system, be moved from clinical APC 422 back into new technology APC 1555 until further data are available (Presentation 4).

Miscellaneous APC Issues

Ms. Spolter and CMS Staffer Carol Bazell identified some violations of the two-times rule and presented CMS staff proposals to rectify them. The Panel reviewed the suggestions and made the following recommendations:

The Panel recommends that CMS restructure sigmoidoscopy APCs 146 and 147 as suggested by CMS staff and Panel members to eliminate violations of the two-times rule.

The Panel recommends that CMS restructure the posterior segment eye procedures (APCs 235, 236, 237, and 672) as suggested by CMS staff to eliminate violations of the two-times rule.

The Panel recommends that CMS restructure pathology APCs 342, 343, 344, and 661 as suggested by CMS staff to eliminate violations of the two-times rule.

The Panel recommends that CMS restructure the female reproductive procedure APCs 189, 192, and 193 as suggested by CMS staff to eliminate violations of the two-times rule.

The Panel recommends that CMS restructure APCs 601 and 602, mid- and high-level clinic visits, as suggested by CMS staff to eliminate violations of the two-times rule.
The Panel recommends that CMS restructure angiography and venography APCs 668,

279, and 280 as suggested by CMS staff to eliminate violations of the two-times rule. The Panel also recommends that HCPCS code 75822 be moved to APC 668 and that APC 281 be eliminated.

The Panel recommends that CMS restructure vascular access APCs 32, 109, 115, 119, 124, and 187 into APCs 32 (Level 1), 119 (Level II), 124 (Level III), 115, and 109 as suggested by CMS staff to eliminate violations of the two-times rule.

Kenneth McKusick, M.D., of the Nuclear Medicine APC Task Force observed that the G codes for myocardial positron emission tomography (PET) were replaced by three CPT codes; he asked that CPT codes for myocardial PET be placed in the new technology APC 1513 (Presentation 5) along with the PET codes for tumor imaging as the resources of the various services are very similar. He also asked that CPT code 78730 be moved back to APC 404 from its current APC 340 because he believes the move to APC 340 was based on miscoding.

The Panel recommends that CMS delete all cardiac PET G codes and use appropriate CPT codes for cardiac PET services (effectively eliminating APC 285) and that CPT codes 78459, 78491, and 78492 be moved to new technology APC 1513.

The Panel recommends that CMS move CPT code 78730, urinary bladder residual study, to APC 404, assuming that new data confirm that previous data were derived from incorrectly coded hospital claims.

Robert Weinstein, M.D., representing the American Society of Hematology and the American College of Rheumatology, said he believes CPT code 36515, apheresis, with extracorporeal immunoadsorption and plasma reinfusion, was moved to APC 111 on the basis of faulty data and requested that it be moved back to APC 112 (Presentation 6). Patricia Jost Golden, R.N., of the American Society for Apheresis concurred (Presentation 7).

The Panel recommends that CMS move CPT code 36515, apheresis, with extracorporeal immunoadsorption and plasma reinfusion, to APC 112.

Julie Ann Stoughton of MD Surgical Care requested that CPT codes 36475 and 36476 for endovenous radiofrequency ablation be moved from APC 92 to an APC that would reimburse for the procedure at about $2,500 and more appropriately describe the procedure (Presentation 8). Bill Perry of Venous Medical, which manufactures radiofrequency ablation devices, said data had been submitted to CMS, but the Panel felt the data presented at the meeting were insufficient.

The Panel recommends that CPT codes 36475 and 36476 remain in APC 92 until further data are available.

Scott Reid of Boston Scientific asked that CMS move CPT 58563, hysteroscopic endometrial

ablation, currently in APC 387, and CPT 58353, endometrial ablation without hysteroscopic guidance, to APC 202 where CPT 58356, endometrial cryoablation, currently resides for better clinical and resource homogeneity (Presentation 9). Gail Daubert, speaking on behalf of American Medical Systems, which manufactures cryoablation devices, spoke against Mr. Reid's request.

> *The Panel recommends* that CPT codes 58563, 58353, and 58356 remain in their current APCs.

Sue DeSantis, James Tyler, Al Dobson, Lane Koenig, and David Main of the Hyperbaric Oxygen Therapy Association said CMS claims data on hyperbaric oxygen therapy do not accurately reflect the costs of the therapy because of hospital miscoding (Presentation 10) and OPPS conversion of charges to costs using a cost-to-charge ratio, which does not reflect a correct ratio for hyperbaric oxygen therapy. They asked that the reimbursement rate be increased on the basis of external data supplied by the association and that hyperbaric oxygen therapy have a designated reporting line on the Medicare cost report so that CMS can collect accurate data and calculate an appopropriate cost-to-charge ratio to convert charges for hyperbaric oxygen therapy to costs..

The Panel reviewed comments submitted by Isador Lieberman, M.D., requesting that HCPCS codes S2362 and S2363 for kyphoplasty be assigned to new technology APC 1535 (Presentation 11).

Mark Zalis, M.D., of Massachusetts General Hospital and Harvard Medical School, raised concerns about the current APC placement of computed tomographic angiography and said the American College of Radiology will present the Panel with a recommendation on the issue at an upcoming meeting (Presentation 12). Dr. Zalis then described the process and benefits of diagnostic computed tomographic colonography (0067T) and requested that it be moved from clinical APC 332 to a new technology APC (Presentation 13).

> *The Panel recommends* that CMS move diagnostic computed tomography colonography, code 0067T, to APC 333.

Drug Administration for 2006

Ms. Heygster explained that Q codes were discontinued in 2004, but 2005 drug administration reimbursement rates are based on 2003 data, and 2006 rates will be based on 2004 data (both using Q codes). In 2006, hospitals will be required to use the new CPT codes for drug administration claims. Jugna Shah of Nimmitt Consulting said that in January 2005, hospitals had only 2 weeks' notice to switch from one coding method to another and more transition time will be needed to implement changes in 2006. Ms. Leon-Chisen of the AHA said the accuracy of data is likely to suffer whenever a transition occurs and suggested an extended transition period. Ms. Heygster noted the elimination of the "grace period" in 2005 resulted from Health Insurance Portability and Accountability Act (HIPAA) requirements.

The Panel recommends that CMS continue to use CPT codes for drug administration.

The Panel reviewed comments submitted by the Oncology Nursing Society requesting guidance from CMS on how to code and bill for oncology supportive care services (Presentation 14). Ms. Shah of Nimmitt Consulting asked that CMS publish guidance on what constitutes a separately identifiable evaluation and management service in relation to oncology supportive services.

Overview of Drugs, Biologicals, and Radiopharmaceuticals

CMS Staffer Sabrina Ahmed gave an overview of 2005 changes to HOPPS for drugs, biologicals, and radiopharmaceuticals. She noted that the Medicare Payment Advisory Commission (MedPAC) is preparing a report on hospital drug overhead and related expenses for separately covered outpatient drugs. The Government Accountability Office (GAO) is studying hospital drug acquisition costs.

Ernest Anderson Jr. and Wendy Andrews of the Association of Community Cancer Centers said the MedPAC report gathered data from only four hospitals, and their organization would like to review the report before it is finalized (Presentation 15). They asked that CMS devise a uniform methodology for reimbursing all separately payable, non-pass-through drugs. They requested that, for 2006, CMS provide an adjustment to the average-sales-price-based reimbursement for pass-through drugs, similar to additional payments established in the Physician Fee Schedule for drug administration and for the cancer chemotherapy patient demonstration project.

Beth Roberts of Hogan and Hartson, on behalf of the Biotechnology Industry Organization, suggested that a new rate-setting methodology for separately covered outpatient drugs should be applied to all the separately-paid drugs and that CMS should work with the GAO and MedPAC to gather sufficient data (Presentation 16). She asked the Panel to urge CMS to insist the GAO also study the issue in 2005, as mandated by law, to ensure current data are available to set future rates.

Blood and Blood Products

Ms. Yen described the methodology behind changes in reimbursement for blood and blood products for 2005. Overall, payment medians rose an average of 25 percent for 2005, she said. Dr. Anne Eder of the American Red Cross pointed to continuing challenges to maintaining a sufficient blood supply and requested that 1) reimbursement rates for 2006 be at least equal to or, where appropriate, higher than 2005 rates, 2) 2006 rates for high-volume products be increased to adequately cover the costs of the products, and 3) 2006 rates for low-volume products be restored to 2004 rates at a minimum (Presentation 17). Ms. Sanow said the Agency hopes to provide guidelines on hospital outpatient billing for blood and blood products in the near future.

The Panel recommends that CMS continue to work with the American Red Cross and others to resolve issues related to reimbursement so that hospitals can maintain a reasonable blood supply for outpatient services.

Closing

The Panel reviewed the recommendations from the meeting. Dr. Hambrick thanked the outgoing Panel members for their service and the CMS and support staff, especially Shirl Ackerman-Ross, for their hard work.

Dr. Hambrick adjourned the meeting at 3:30 p.m. on Thursday, February 24, 2004.

Respectfully Submitted,

Shirl Ackerman-Ross
DFO, APC Panel, FACA

Appendix A

AGENDA

February 23 and 24, 2005

ADVISORY PANEL ON AMBULATORY PAYMENT CLASSIFICATION (APC) GROUPS' MEETING

DAY 1 - Wednesday, February 23, 2005

Notes:
[1]Public registrants may enter the CMS Central Office Building after 12:15 p.m.

[2]NO meeting is scheduled for Friday, February 25, 2005, as indicated in the **Federal Register** notice of December 30, 2004.

TAB

08:30 – Subcommittee Meetings

10:15 – *Break*

10:30 – Subcommittees meet with full Panel

12:00 – *Lunch*

01:00 Opening - Day 1
Welcome, Call to Order, Introduction of New Members, and Opening Remarks
Elizabeth Richter, Director, Hospital and Ambulatory Policy Group

01:30 Panel Organization and Housekeeping Issues
E. L. Hambrick, M.D., Chair

01:45 Overview of CMS-1427-FC, Final Rule for the Hospital Outpatient Prospective Payment System and Calendar Year 2005 Payment Rates **A**
a. Dana Burley, CMS Staff
b. Panel's Comments/Recommendations

02:00 Data Issues **B**

a. Low-Volume List and Pattern Analysis
   Anita Heygster, CMS Staff
b. Stereotactic Radiosurgery
   Debbie Hunter, CMS Staff
c. Revenue Center List
   Tamar Spolter, CMS Staff
d. OPPS Inpatient List
   Cindy Yen, CMS Staff
e. Payment for Reduced Services (52/73/74 Modifiers)
   Anita Heygster, CMS Staff
f. Data Subcommittee's Report
g. Discussion
h. Panel's Recommendations

03:00 Observation Issues **C**

a. Overview
   Joan Sanow, Acting Director, Division of Outpatient Care
b. **Provider Roundtable's Presentation – Jennifer L. Artigue, RHIT**
   (G-0244 & G-0263) - Marion Kruse, R.N.
   - Valerie A. Rinkle, MPA
c. Observation Subcommittee's Report
d. Discussion
e. Panel's Recommendations

04:00 Packaging Issues **D**

a. Packaged Codes Billed with No Other Service
   Tamar Spolter, CMS Staff
b. Provider Roundtable's Presentation – Jennifer L. Artigue, RHIT
   (Incidental or "N" Status HCPCS) - Marion Kruse, R.N.
   - Valerie A. Rinkle, MPA
c. Packaging Subcommittee's Report
d. Discussion
e. Panel's Recommendations

05:00 Adjourn

AGENDA

February 23 and 24, 2005

ADVISORY PANEL ON AMBULATORY PAYMENT CLASSIFICATION (APC) GROUPS' MEETING

DAY 2 - Thursday, February 24, 2005

Note: Public registrants may enter the CMS Central Office Building after 7:45 a.m.

TAB

08:30 Opening - Day 2
- a. Welcome and Call to Order
- b. Edith Hambrick, M.D., Chair

08:35 Device-Related and New Technology APC Issues **E**
- a. "C" Code Data for Device-Dependent APCs
  Anita Heygster, CMS Staff
- b. **AdvaMed's Presentation - Jane Hyatt Thorpe, Assoc. VP**
  (Device costs associated with selected APCs)
- c. **C. R. Bard's Comments (APC 0422)**
- d. Discussion
- e. Panel's Recommendations

09:45 Miscellaneous APC Issues **F**
- a. 2X-Violation Issues
  Tamar Spolter, CMS Staff
- b. Vascular Access Codes
  Dana Burley, CMS Staff

10:15 *Break*

10:30 Miscellaneous APC Issues (*continued*) **F** (cont'd)
- **a. NMAPCTF's Presentation - Kenneth McKusick, M.D**
  (Placement of Nuclear Medicine CPT Codes in APCs)

TAB

10:30 Miscellaneous APC Issues (*continued*) **F** (cont'd)

- **b. ASH/ACRh's Presentation - Robert Weinstein, M.D.**
  (Placement of 36515 in APC 0111)
- **c. ASFA's Presentation - Patricia Jost Golden, R.N.**
  (APCs 0112 and 0111)
- **d. Boston Scientific's Presentation - Scott Reid, Senior Manager**
  (Improving Endometrial Ablation Groupings)
- **e. MD Surgical Care's Presentation - Julian Stoughton, M.D., F.A.C.S.**
  (Endovenous RF Ablation)
- **f. HOTA's Presentation - Sue DeSantis, Exec. Dir.**
  (APC 0659) - James Tyler, Pres., HOTA
  - Al Dobson, Consultant
  - Lane Koenig, Consultant
  - David Main, Consultant
  - Mark Lieberman, Consultant
- **i. Kyphoplasty Presentation - (Kyphoplasty APC Assignment)**
  (Dr. Isador Lieberman is unable to attend; please consider his presentation as "comments.")
- **j. MGH's Presentation - Michael Zalis, M.D.**
  (CTA)
- **k. MGH's Presentation - Michael Zalis, M.D.**
  (CT Colonography)
- l. Discussion
- m. Panel's Recommendations

12:00 *Lunch*

01:00 Drug Administration for 2006 **G**

- a. Overview
  Anita Heygster, CMS Staff
  Oncology Nursing Society's Comments (Cancer-related care)
- b. Discussion
- c. Panel's Recommendations

01:30 Drugs, Biologicals, and Radiopharmaceuticals **H**

- a. Overview - Sabrina Ahmed, CMS Staff
- **b. ACCC's Presentation – Ernest R. Anderson, Jr.**
  (Drugs and Biologicals APCs) - Wendy Andrews
- **c. BIO's Presentation - Terese M. Ghio**
  (Drugs and Biologicals APCs)
- d. Discussion
- e. Panel's Recommendations

TAB

02:30 Blood & Blood Products **I**

a. Overview
   Cindy Yen, CMS Staff
b. **ARC's Presentation - Dr. Anne Eder**
   (Blood and Blood Product APCs)
c. Discussion
d. Panel's Recommendations

03:00 *Break*

03:30 Closing

a. Summary of the Panel's Recommendations for 2006 **J**
b. Discussion
c. Final Remarks

05:00 Adjourn

Appendix B

APC Panel Recommendations

February 23–24, 2005

Agenda Item B: Data Issues

The Advisory Panel on Ambulatory Payment Classification (APC) Groups (the Panel) recommends removing the following Current Procedural Terminology (CPT) codes from the inpatient-only list:

33420	59100	21408	21150
55600	20822	21495	20663
31293	64763	61334	20972
31294	54560	21175	59856
00634	01190	64766	27475
20662	37195	20973	37183
65273	36510	21195	

The Panel recommends that the Centers for Medicare & Medicaid Services (CMS) create a single G code to encompass planning for stereotactic radiosurgery (SRS), that the code be assigned to the new technology APC, and that the issue of planning codes for SRS be brought before the Panel for review in 2006.

The Panel recommends no changes to the current G codes for delivery of SRS. However, the Panel recommends that CMS staff review the current data and provide the Panel with possible scenarios for moving SRS delivery codes from the new technology APC into individual existing or new APCs.

The Panel recommends that claims submitted with modifier 52, 73, or 74 be paid at 100 percent of the reimbursement rate (and not reduced).

For APC 107, the Panel recommends that CPT code 33241 be added to the bypass list.

For APC 108, the Panel recommends that CPT codes 93640 and 93641 be packaged.

The Panel recommends that CMS analyze APCs 081 and 229 for patterns related to multiple claims.

The Panel recommends that the Data Subcommittee continue to meet and evaluate issues.

Agenda Item C: Observation Issues

The Panel recommends that CMS consider strategies that would allow hospitals to change to the appropriate inpatient or outpatient status after patient discharge but before the patient or payor is billed.

The Panel recommends that CMS review data on 1-day stays among inpatient diagnosis-related groups to look for patterns of diagnoses that might be considered appropriately included on the list of diagnoses for observation status.

The Panel recommends that CMS gather data from Quality Improvement Organizations regarding 1-day stay audits among inpatient diagnosis-related groups to look for patterns of diagnoses that might be considered appropriately included on the list of diagnoses for observation status.

The Panel recommends that the Observation Subcommittee continue to meet and evaluate issues.

Agenda Item D: Packaging Issues

The Panel recommends that packaged codes be reviewed by the Panel individually.

The Panel recommends that the Packaging Subcommittee continue to meet throughout the year to discuss problematic packaged codes.

The Panel recommends that CMS assign a modifier to CPT codes 36540 (collect blood, venous device), 36600 (withdrawal of arterial blood), and 51701 (insertion of bladder catheter) for use when one of these codes is the only code on a claim. The modifier would flag the OCE to assign payment to the claim.

The Panel recommends that CMS maintain the current packaged status indicator for CPT 76937.

The Panel recommends that CMS change the status indicators for CPT immunization administration codes 90471 and 90472 to allow separate payment and ensure consistency with other injection codes.

The Panel recommends that CMS gather more data on CPT 94762 (overnight pulse oximetry) to determine how often this code is billed without any other payable codes and whether it is performed more frequently alone in rural settings than other settings.

The Panel recommends no changes to the packaged status of CPT codes 77790, 94760, and 94761.

The Panel recommends that CMS provide education and consistent guidelines to providers and fiscal intermediaries on correct billing procedures for packaged codes in general and in particular for CPT codes 36540, 36600, and 51701 and the recommended modifier, if approved.

The Panel recommends that the Packaging Subcommittee review the following CPT codes:
42550
38792

The Panel recommends that CPT 97602 be referred to the Physician Payment Group for evaluation of nonpayment status as it relates to services provided under the Outpatient Prospective Payment System and that the Physician Payment Group report its conclusions back to the Panel.

Agenda Item E: Device-Related and New Technology APC Issues

The Panel recommends that CMS implement the second and third edits for device coding together in July 1, 2005.

The Panel recommends that CMS proceed with caution in using existing data on devices submitted with C codes to set reimbursement rates and that CMS consider using external data in setting such rates, especially for those devices with particularly high costs. The Panel recommends that CMS review and report to the Panel on those situations in which the 2006 median is less than 90 percent or greater than 110 percent of the 2005 adjusted median. When the 2006 median is between 90 and 110 percent of the 2005 adjusted median, the Panel recommends that CMS set reimbursement rates at the higher of the two figures. The Panel recommends that CMS bring data on this issue back to the Panel for consideration when CMS has gathered at least one year of applicable data.

Agenda Item F: Miscellaneous APC Issues

The Panel recommends that CMS restructure sigmoidoscopy APCs 146 and 147 as suggested by CMS staff and Panel members to eliminate violations of the two-times rule.

The Panel recommends that CMS restructure pathology APCs 342, 343, 344, and 661 as suggested by CMS staff to eliminate violations of the two-times rule.

The Panel recommends that CMS restructure the female reproductive procedure APCs 189, 192, and193 as suggested by CMS staff to eliminate violations of the two-times rule.

The Panel recommends that CMS restructure APCs 601 and 602 (mid- and high-level clinic visits) as suggested by CMS staff to eliminate violations of the two-times rule.

The Panel recommends that CMS restructure APCs 668, 279, and 280 as suggested by CMS staff to eliminate violations of the two-times rule. The Panel also recommends that HCPCS code 75822 be moved to APC 668 and that APC 281 be eliminated.

The Panel recommends that CMS restructure APCs 32, 109, 115, 119, 124, and 187 into APCs 32 (Level 1), 119 (Level II), 124 (Level III), 115, and 109 as suggested by CMS staff to eliminate violations of the two-times rule.

The Panel recommends that CMS delete all cardiac positron emission tomography (PET) G codes and use appropriate CPT codes for cardiac PET services (effectively eliminating APC 285), and that CPT codes 78459, 78491, and 78492 be moved to new technology APC 1513.

The Panel recommends that CMS move CPT code 78730, urinary bladder residual study, to APC 404, assuming that new data confirm that previous data had been incorrectly reported.

The Panel recommends that CMS move CPT code 36515, apheresis, with extracorporeal immunoadsorption and plasma reinfusion, to APC 112.

The Panel recommends that CPT codes 36475 and 36476 remain in APC 92 until further data are available.

The Panel recommends that CPT codes 58563 (APC 387), 58353 (APC 195), and 58356 (APC 202) remain in their current APCs.

The Panel recommends that CMS move diagnostic computed tomography colonography, code 0067T, to APC 333.

Agenda Item G: Drug Administration for 2006

The Panel recommends that CMS continue to use CPT codes for drug administration.

Agenda Item I: Blood and Blood Products

The Panel recommends that CMS continue to work with the American Red Cross and others to resolve issues related to reimbursement so that hospitals can maintain a reasonable blood supply on an outpatient basis.

Appendix C

Presentations/Comments

The following documents were presented at or submitted for the APC Panel meeting February 23–24, 2005, and are appended here for the record:

Presentation 1:	Provider Roundtable (Observation)
Presentation 2:	Provider Roundtable (Packaging)
Presentation 3:	Advanced Medical Technology Association (AdvaMed)
Presentation 4:	C. R. Bard
Presentation 5:	Nuclear Medicine APC Task Force
Presentation 6:	American Society of Hematology and American College of Rheumatology
Presentation 7:	American Society for Apheresis
Presentation 8:	MD Surgical Care
Presentation 9:	Boston Scientific, Inc.
Presentation 10:	Hyperbaric Oxygen Therapy Association
Presentation 11:	Isador Lieberman, M.D.
Presentation 12:	Massachusetts General Hospital/Harvard Medical School (Computed Tomography Angiography)
Presentation 13:	Massachusetts General Hospital/Harvard Medical School (Computed Tomography Colonography)
Presentation 14:	Oncology Nursing Society
Presentation 15:	Association of Community Cancer Centers
Presentation 16:	Biotechnology Industry Association
Presentation 17:	American Red Cross